

Patient Account: 20005972-517
 Med. Rec. No.: (0150)1578039
 Patient Name: TOGONIDZE, ALEXANDER
 Age: 45 YRS DOB: 12/02/66 Sex: M Race: C
 Admitting Dr.: OUTSIDE TDCJ
 Attending Dr.: OUTSIDE TDCJ
 Date / Time Admitted : 08/09/11 1340
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 Galveston, Texas 77555-0543
 (409) 772-1238
 Fax (409) 772-5683
 Pathology Report

1578039

FINAL AUTOPSY REPORT

Autopsy Office (409)772-2858

Autopsy No.: AU-11-00167

AUTOPSY INFORMATION:

Occupation: INMATE Birthplace: UNKNOWN Residence: TEXAS
 Date/Time of Death: 8/8/2011 08:15 Date/Time of Autopsy: 8/10/2011
 Pathologist/Resident: CAMPBELL/DIVATIA Service: TDC CONTRACT
 Restriction: NONE

The on-line version of the final autopsy report is abbreviated. If you would like a copy of the complete final report, or if you have any questions regarding this report, please contact the Autopsy Division Office, (409)772-2858.

FINAL AUTOPSY DIAGNOSIS

- I. Body as a whole: Clinical history of hypertension, hyperlipidemia, diabetes mellitus and hyperthermia (terminal body temperature greater than 106 degrees Fahrenheit) C1-3
 - A. Organs in situ: Severe autolytic changes A4
- / B. Pulmonary system:
 - 1. Lungs, bilateral: Congestion and edema (weights: right, 730 gm and left, 620 gm) A4
- / C. Cardiovascular system:
 - 1. Pulmonary arteries: No thromboemboli identified A4
 - 2. Coronary arteries: Moderate atherosclerosis with maximal stenosis of 40% (right coronary artery) A4
 - a. Heart: No evidence of myocardial infarct A4

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***TYPE: Anatomic(A) or Clinical(C) Diagnosis.
 IMPORTANCE: 1-immediate cause of death (COD); 2-underlying COD;
 3-contributory COD; 4-concomitant, significant; 5-incidental ***

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CLINICAL SUMMARY:

The deceased is a 44 year old Caucasian TDCJ inmate with a past medical history of diabetes mellitus, who was found unresponsive in his cell on 8-8-11 at approximately 07:50 am. Cardiopulmonary resuscitation was initiated. The vital signs recorded at this time were body temperature greater than 106 degrees Fahrenheit, pulse 162/min, respirations 40/min, and blood pressure 60/40 mmHg. An automatic external defibrillator was used which advised no shock and to continue resuscitation. Upon arrival, emergency medical services applied a heart monitor/defibrillator which showed asystole, and resuscitation was subsequently stopped. The patient was declared dead on 8-8-11 at 8:15 a.m. A complete autopsy was performed on 08-10-11 at 10:00 a.m.

Prescribed medications recorded in supplied Correctional Managed Care Urgent/Emergent Care records include the following:

Ecotrin (aspirin)
 Tenformin (atenolol - beta blocker)
 Benzac gel
 Tegretol (carbamazepine)
 Vasotec (enalapril - angiotensin converting enzyme inhibitor)
 Pamelor (nortriptyline - tricyclic antidepressant)
 Prilosec (omeprazole)
 Pravachol (pravastatin)
 Glucophage (metformin).

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GROSS DESCRIPTION:

EXTERNAL EXAMINATION: The decedent, identified by left wrist band as "Alexander Togonidze", is a well developed, well nourished, Caucasian male, measuring 167 cm in length, and weighing approximately 188 lbs according to recent medical records. The general appearance is consistent with the reported age of 44 years. No personal belongings are accompanying the body. Rigor mortis is present in the arms and legs and there is fixed lividity on the dorsal surface. The head is normocephalic with short scalp hair (1.5 cm).

The pupils are equal and measure 0.3 cm in diameter. The corneas are cloudy, the conjunctivae and sclerae are mildly congested. The nares are patent without exudate. Dentition is adequate. Buccal membranes are pale without lesions. The trachea is midline. Palpation of the neck reveals no lymphadenopathy or thyromegaly.

Body hair distribution is that of a normal male. The chest diameters are normally proportioned. The abdomen is slightly protuberant. Lymph nodes in the supraclavicular, axillary and inguinal regions are not palpable.

The back is normal. The arms and legs are unremarkable. The genitalia are those of a normal male for the age.

INTERNAL EXAMINATION: The body is opened using a standard Y shaped incision, to reveal a 2.5 cm thick panniculus and the thoracic and abdominal organs in the normal anatomic positions. The left and right pleural cavities contain 10 and 15 ml of clear fluid respectively.

The pericardial sac contains minimal clear fluid.

The 3rd and 4th right ribs and 3rd to 5th left ribs are fractured following cardiopulmonary resuscitation.

The thymus is largely replaced by fat. No thromboemboli are found in the large pulmonary arteries. The height of the left diaphragm is at the 9th intercostal space in the mid axillary line.

The abdominal cavity contains minimal clear fluid (15-20 ml). There are no peritoneal adhesions.

CARDIOVASCULAR SYSTEM: Heart: The heart weighs 300 gm (normal male 270-360) and is normal in shape. The pericardium is unremarkable. The heart is examined by transverse serial slicing; opening following the flow of blood. The myocardium is homogeneous red-brown without scars, infiltrates or lesions. The endocardium is smooth and transparent. The left ventricular wall is 1.4 cm thick (normal 1.0-1.8 cm) at the junction of the posterior papillary muscle

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GROSS DESCRIPTION:

and free wall, and the right ventricle is 0.4 cm thick (normal 0.25-0.3 cm) 2 cm below the pulmonic valve annulus, anteriorly. The valve leaflets and cusps are white, delicate and membranous with the exception of the aortic valve which has demonstrated cusps.

Valve circumferences measured on the fresh heart are: tricuspid valve 12.8 cm (normal 12-13 cm), pulmonic valve 8.7 cm (normal 8.5-9.0 cm), mitral valve 11.6 cm (normal 10.5-11.0 cm), and aortic valve 8.1 cm (normal 7.7-8.0 cm). The foramen ovale is closed.

Blood vessels: The coronary circulation is right dominant based on the origin of the posterior descending artery. The apex is supplied by the left coronary arteries. The coronary arteries reveal moderate atherosclerotic plaques with up to 40% stenosis of the right coronary artery located 10.5 cm from the origin. There is no evidence of hemorrhage, rupture/thrombosis of the plaques. The aorta exhibits atherosclerotic plaques without ulceration or calcification (10 % of this area involved by plaques) in the thoracic and abdominal portions. The celiac, superior and inferior mesenteric, renal and iliac arteries are normal. The superior and inferior vena cavae and their branches are normal. The portal vein is normal.

RESPIRATORY SYSTEM: Larynx and trachea: The laryngeal mucosa and vocal cords are normal. The tracheal mucosa is normal.

Lungs: The right lung weighs 730 gm (normal male 435), and the left 620 gm (normal male 385). The pleural surfaces are congested with anthracotic areas. Lividity is dorsal. The left lung is inflated with formalin before sectioning and the right lung is examined unfixed. The bronchial and vascular trees are normal. The hilar nodes are normal. The lung parenchyma and both the lungs is congested and edematous.

GASTROINTESTINAL TRACT: Esophagus: The esophageal mucosa is normal. The esophagus is firmly anchored to the diaphragm.

Tongue: The tongue is normal.

Stomach and duodenum: The stomach contains approximately 30 to 40 ml of dark colored fluid. The mucosa is predominantly autolyzed.

The duodenal mucosa is normal.

Pancreas: The pancreas and pancreatic duct are normal. The pancreatic duct is patent.

Biliary tract: The gallbladder mucosa, wall and serosa are normal. The

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gallbladder contains approximately 12 ml of dark green thin bile. No stones are identified. The wall measures up to 0.5 cm in thickness. The cystic duct, hepatic duct, and common duct are normal. The bile is freely expressed from the ampulla on compressing the gallbladder.

Liver: The liver weighs 1320 gm (normal male 1400-1900). The cut surface of the liver is unremarkable. No discrete lesions are identified.

Small Bowel: The mucosal and serosal surfaces of the small bowel are normal. The lumen contains fecal material. The wall is 0.4 cm thick.

Large bowel: The mucosal and serosal surfaces are normal. The lumen contains feces. No discrete lesions are identified.

The appendix is grossly normal.

Rectum and anus: The rectum and anus are normal.

Reticulo-Endothelial System: Spleen: The spleen weighs 200 gm (normal 125-195 gm). It is normal in shape, size, density and color.

Lymph nodes: Lymph nodes in the mediastinum, abdomen and retroperitoneum are unremarkable.

Spine: The spine is normal.

Bone marrow: The thoracic and lumbar spine marrow is grossly normal. The trabeculae and cortical bone are normal density.

GENITO-URINARY SYSTEM: Kidneys: The kidneys are symmetric. The right and left kidneys weigh 170 and 160 gm respectively (normal male 125-170 gm). The capsules strip with ease to reveal dark brown unremarkable cortical surfaces. Serial slicing reveals well demarcated cortico-medullary junctions. The cortices are 0.4 cm thick; the medullas 1.4 cm thick. The pelvis and calyces are normal. The renal pelvic mucosa is normal. Perihilar adipose tissue is normal.

Ureters: The ureters are normal throughout their length, measuring 0.2 cm in maximal external diameter. They are probe-patent into the bladder.

Bladder: The bladder is normal. The trigone is normal.

Prostate: The prostate is normal in size, color, consistency, and texture. The cut surface of the prostate is unremarkable. No discrete lesions are identified. The seminal vesicles are normal.

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GROSS DESCRIPTION:

Testes: The right and left testes weigh 26.7 and 25 gm respectively (normal 20-25 gm). The cut surface of both the testes is normal. No discrete lesions are identified.

ENDOCRINE SYSTEM: Thyroid: The thyroid weighs 26.5 gm (normal 10-22 gm), and is red-brown and bosselated. The cut surface is homogeneous and red-brown. No discrete lesions are identified.

Adrenal glands: The right and left adrenal glands weigh 6.2 and 5.7 gm respectively (normal 5-6 gm). The cut surface of both adrenal glands are normal. No discrete lesions are identified.

BRAIN AND SPINAL CORD: The scalp, calvarium, base of the skull and dura mater are normal. The brain weighs 1500 gm (normal male 1200-1400). The gyri and sulci display a normal pattern without significant edema or atrophy. The leptomeninges are normal. The circle of Willis, basilar and vertebral arteries show mild atherosclerosis. No indentation/herniation of the cingulate gyri, unci or molding of the cerebellar tonsils are noted. The brain is fixed in formalin for later examination by a neuropathologist (see neuropathology report).

SPINAL CORD: The grossly normal spinal cord is fixed in formalin for later examination by a neuropathologist.

PITUITARY GLAND: The grossly normal pituitary gland is fixed in formalin for subsequent examination by a neuropathologist.

During the autopsy, blood and vitreous samples were retained for potential further testing. Samples of liver, kidney, heart, lung, and spleen, were frozen for potential further examination.

Blood from heart was submitted for comprehensive toxicologic analysis, and vitreous fluid was submitted for electrolyte analysis (testing laboratory: Aegis Crimes, Aegis Sciences Corporation, Nashville, TN).

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Autopsy Office (409)772-2858

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MICROSCOPIC DESCRIPTION:

Thyroid (slide 1A, H&E): No pathologic change.

Adrenal gland (slide 2A, H&E): No pathologic change, examination limited by autolysis.

Testis (slide 2A, H&E): No pathologic change. Spermatogenesis present.

Spleen (slide 3A, H&E): Reduction of white pulp, examination limited by autolysis.

Pancreas (slide 4A, H&E): No evident pathologic change, examination limited by severe autolysis.

Kidneys (right: slide 5A; left: slide 6A; H&E): Mild interstitial fibrosis, examination limited by autolysis.

Prostate gland (slide 7A, H&E): No pathologic change.

Vertebral body (slide 8A, H&E, decalcified): Cellularity: 60%; normal marrow trilineage cellular composition; normal bony trabeculae.

Liver (slide 9A, H&E): Steatohepatitis, macro and micro, centrilobular, moderate.

Colon (slide 10A, H&E): No pathologic change.

Ileum (slide 11A, H&E): No pathologic change.

Lung, left apex (slide 12A, H&E): Healed granulomas with central necrosis, consistent with old (inactive) tuberculosis.

Lungs (left: slide 13A; right: slides 14A-16A; H&E): Congestion and edema; post-mortem intravascular bacterial growth present.

Heart (right: slide 17A; left: slides 18A-19A; H&E): No pathologic change, examination limited by severe autolysis.

Coronary artery, right (slide 20A, H&E): Atherosclerosis, 40% maximal stenosis.

Blood toxicologic and vitreous electrolyte analysis results and interpretations:

Positive toxicologic results:

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MICROSCOPIC DESCRIPTION:

Carbamazepine: 2.5 mcg/mL (reporting threshold 2 mcg/mL) - within therapeutic range

Nortriptyline: 751 ng/mL (reporting threshold 50 ng/mL) - somewhat above therapeutic range of 50-375 ng/mL and above level of 500 ng/mL at which toxicity has been reported. Effects of toxicity include cardiac arrhythmias. A reported lethal level is 13,000 ng/mL. Because the source of blood in this case was heart, artifactual post-mortem concentration is a possible factor in the elevated level of this drug.

All other analytes were negative.

Vitreous analysis results:

Urea Nitrogen: 38 mg/dL (reporting threshold 1 mg/dL) - mildly elevated (normal 8-20 mg/dL)

Sodium (Na): 123 mmol/L (reporting threshold 1 mmol/L) - decreased (normal 135-150 mmol/L)

Potassium (K): >9 mmol/L (reporting threshold 1 mmol/L) - normal (normal < 15 mmol/L)

Creatinine: 1.6 mg/dL (reporting threshold 0.1 mg/dL) - mildly increased (normal 0.6-1.3 mg/dL)

The above vitreous findings are somewhat consistent with hyponatremic dehydration, however chloride is normal (usually decreased in that condition).

References:

1. Winek CL, et al. Drug and chemical blood level data 2001. *Forensic Sci. Int.* 122:107-123, 2001.
2. Collins KA. Postmortem vitreous analyses. *Medscape Reference, Drugs, Diseases and Procedures*. [online: <http://emedicine.medscape.com/article/1966150>], 2011.

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Pathology Report

NEUROPATHOLOGY CONSULTATION

Neuropath Office (409)772-2881

Autopsy No.: AU-11-00167

CLINICAL HISTORY:

The deceased is a 44 year old Caucasian TDCJ inmate with a past medical history of diabetes mellitus, who was found unresponsive in his cell on 8-8-11 at approximately 07:50 a.m. Cardiopulmonary resuscitation was initiated. The vital signs at this time were temperature greater than 106 degrees Fahrenheit, pulse 162/min, respirations 40/min, and blood pressure 60/40 mmHg. An automatic external defibrillator was used which advised no shock and to continue resuscitation. Emergency medical services arrived and an electrocardiogram was performed and analyzed. It showed asystole, and resuscitation was subsequently stopped. The patient was declared dead on 8-8-11 at 8:15 a.m.. An autopsy was performed on 08-10-11 at 10:00 a.m. The cause of death in this patient is hyperthermia and the manner is accidental.

PATHOLOGIST/RESIDENT: CAMPBELL/DIVATIA

GROSS DESCRIPTION:

Submitted for neuropathologic examination are brain (unfixed weight 1500 g), convexity and posterior fossa dura, spinal cord with spinal dura (length 29 cm, conus medullaris and filum terminale present), and pituitary gland.

The dura is grossly unremarkable. There is no evidence of significant jaundice staining. There is no evidence of acute hemorrhages, subdural membranes, or masses. There is no evidence of thrombosis of the superior sagittal sinus.

External examination reveals the brain to be intact and normally developed with transparent convexity leptomeninges. There is mild gyral flattening, but no evidence of arachnoid hemorrhage, exudate, focal softening, discoloration, atrophy, or herniation. The major cerebral arteries have no significant atherosclerosis. The circle of Willis has a normal symmetric pattern, and no aneurysms or other malformations are identified.

The hemispheres are sliced coronally, revealing normal anatomic development and normal cerebral ventricles. The cerebral white matter is expanded and soft and pink due to incomplete fixation, and the gray-white junction is focally indistinct. No focal gross lesions are identified in the hemispheres. The brainstem and cerebellum are separated through the cerebellar peduncles, and the cerebellum is sliced sagittally and the brainstem transversely. Both structures are normally developed, and have normal pigmentation of substantia nigra and locus ceruleus. There is no evidence of gross lesions.

The spinal dura is opened anteriorly, revealing no evidence of extradural, subdural or arachnoid hemorrhage. The spinal cord is sliced transversely at 0.5 to 1 cm intervals, revealing normal development and no evidence of parenchymal lesions.

The pituitary gland is intact and normally developed, without external

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GROSS DESCRIPTION:

hemorrhages or other lesions. The horizontal cut surface reveals a darkly colored anterior lobe, but no evidence of focal internal lesions.

Photographs made during gross brain examination: none.

DICTATED BY: GERALD A. CAMPBELL, M.D., PATHOLOGIST
06/27/12

SECTIONS TAKEN:

B1: Pituitary gland; B2: Right frontal, area 8; B3: Left basal ganglia; B4: Right cerebellum; B5: Right hippocampus.

FINAL DIAGNOSES:

A. Brain and cranial dura (weight 1500 g):

1. Brain: Cerebral edema, moderate (negative for herniations)
2. Cerebral cortex and white matter: Autolytic changes
3. Frontal white matter: Cerebral small vessel disease, mild

B. Spinal cord and spinal dura (29 cm caudal segment): No abnormalities

C. Pituitary gland: No abnormalities

COMMENTS:

Small vessel disease in this context refers to medial thickening and/or hyalinization of small parenchymal arteries and arterioles, and in some cases increased adventitial collagen of small veins and venules.

The on-line version of the final autopsy report is abbreviated. If you would like a copy of the complete final report, or if you have any questions regarding this report, please contact the Autopsy Division Office, (409)772-2858.

GERALD A. CAMPBELL, M.D., PATHOLOGIST
Division of Neuropathology .

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Pathology Report

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CLINICOPATHOLOGIC CORRELATION:

This 44-year-old Caucasian male decedent was found unresponsive in his cell in the Michael Unit in Palestine, Texas at approximately 7:50 am on August 8, 2011. His body temperature was recorded as greater than 106 degrees F., and he was tachycardic, tachypneic and hypotensive prior to cardiac arrest. The maximum environmental temperature for Palestine for the period 8/7 to 8/8/2011 was 104 degrees F. (weathersource.com). The decedent also had chronic diseases, including diabetes and hypertension, that may convey a general risk for hyperthermia, and his prescribed medications included atenolol, a beta blocker, which is known to interfere with cardiovascular response to increased environmental temperatures. Other cardiovascular and psychotropic drugs in this decedent's medication list are also possible factors increasing the risk for hyperthermia. There is no one specific autopsy finding that is universally recognized as diagnostic of death due to hyperthermia, however the results in this case, which included severe autolytic changes in most organs and absence of other anatomic causes of death, are consistent with this conclusion. Post-mortem toxicologic and vitreous electrolyte analyses were inconclusive.

In summary, based on the autopsy findings in combination with the clinical history and circumstances of death discussed above, we conclude that hyperthermia is the cause of death in this case. Chronic diseases, medications and environmental conditions are likely contributory factors. The manner of death is accidental.

GC /GC
06/27/12

GERALD A. CAMPBELL, M.D., PATHOLOGIST
GERALD A. CAMPBELL, M.D., PATHOLOGIST
06/27/12

(Electronic Signature)

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